KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
Health Occupations Credentialing

APPLICATION FOR ADULT CARE HOME OPERATOR REGISTRATION (FOR APPLICANTS WHO COMPLETED OPERATOR TRAINING AFTER JULY 1, 2014)

K.S.A. 39-923 outlines requirements for obtaining Kansas Registration. Please review the statutes.

The three options for obtaining registration are briefly described below and impact how this application form is completed. **Please circle the option under which you are applying for registration.**

Option A Possess a Baccalaureate degree in any area of study
Option B Possess an Associate's degree in a relevant field as determined by the Secretary
Option C Possess a high school diploma or equivalent, with one year relevant experience as determined by the Secretary.

REGISTRATION FEES

Please see fee schedule as fees are pro-rated for partial year licenses. Payment can be submitted by a check made payable to KDADS or by using Visa or MasterCard. Charge authorization form must be completed and signed to utilize this payment option.

APPLICANT INFORMATION

(All applicants must complete this section)

Name: _____
Last, First, Middle (other names used)

Address: _____

Phone: work ( ) home ( ) cell ( )

Email Address: _____

Date of Birth: _____ **Social Security Number** _____

OPERATOR COURSE INFORMATION

(Applies to all applicants)

Please provide a copy of the certificate issued by the school/organization that provided the Operator training course. List organization which provided the Operator Course and date of course completion below:

_____

COLLEGE EDUCATION

(Applies to applicants using options **A** and **B**)

Transcripts must be sent by the college or university directly to Health Occupations Credentialing.

College/University	Degree	Date Conferred
_____	_____	_____
_____	_____	_____
_____	_____	_____

HIGH SCHOOL DIPLOMA OR EQUIVALENT

(Applies to applicants using option **C**)

Verification of high school diploma or equivalent must accompany this application.

WORK EXPERIENCE

(Applies to applicants using Option **C**)

Please list the Employer(s), your job title(s) and employment date(s) below for the work experience being utilized to meet the requirement of one year relevant experience. Verification of the work experience is also required.

_____

_____

DISCIPLINARY ACTION/CONVICTIONS

(Applies to all applicants)

Pursuant to K.S.A. 39-923, has disciplinary action ever been taken against an Operator credential or a professional or occupational health care license held by you, whether issued by this state or another state or jurisdiction and/or have you had a finding of Abuse, Neglect or Exploitation against a resident of an adult care home as defined in K.S.A. 39-1401 and amendments thereto?

Please Circle: YES NO

If YES, please provide specific details and copies of all relevant documents.

Pursuant to K.S.A. 39-923, have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? This includes any felony, misdemeanor, or DUI convictions.

Please Circle: YES NO

If YES, please indicate:

Date of Conviction: _____

City, County and State of Conviction: _____

Crime of which Convicted: _____

NOTE: Candidate shall provide all reports and court documents related to the conviction. The candidate shall have the burden of proving the candidate has been rehabilitated and warrants the public trust.

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the agency to verify any information provided in this application and attachments.

Signature: _____ **Date:** _____

PLEASE NOTE: Your signature must be notarized

SUBSCRIBED AND SWORN TO before me, the undersigned authority,

on this _____ day of_____ 200_____

_____

(Notary Public)

My appointment expires:_____

HEALTH OCCUPATIONS CREDENTIALING
612 S KANSAS AVE, TOPEKA, KS 66603
Adult Care Home
OPERATOR
CRIMINAL RECORD CHECK REQUEST

To be completed by all applicants for Operator Registration who completed the Operator course after July 1, 2014.

LAST NAME | FIRST NAME | MIDDLE NAME | SUFFIX

OTHER LAST NAMES EVER USED

SOCIAL SECURITY NUMBER | DATE OF BIRTH | GENDER | RACE

ONE OF THE FOLLOWING MUST BE SELECTED

A-ASIAN OR PACIFIC ISLANDER
B-BLACK
I-NATIVE AMERICAN/ALASKAN NATIVE
W-WHITE

ADDRESS | POST OFFICE BOX # (IF APPLICABLE)

CITY | STATE | ZIP CODE | HOME PHONE | WORK PHONE

FEES
KANSAS REGISTERED ADULT CARE HOME OPERATORS

A full registration period begins May 1st for a two-year period which expires on April 30th. Initial registrations issued on May 1st of any registration period will be for a full two years. Initial registrations issued at any time during the registration period will be less than two years.

Initial Registration Application*****……. **$65.00**
Note: *The fee for an initial registration period of less than 24 months is prorated. (See chart below)*

Registration Renewal……. **$65.00**
*(**$35.00 additional** if application is postmarked after April 30th but before May 31st)*

Registration Reinstatement…….. **$65.00**
*(**In addition to the registration renewal fee of $65.00** for registration which has lapsed for more than 24 months.)*

***PRO-RATED FEE SCHEDULE**

Applying for Initial registration in the month of:

May	(expires 04/30 2 years later – 24 month registration) $65.00	
June	(23 mos)……..	$62.00
July	(22 mos)……..	$59.00
Aug	(21 mos)……..	$56.00
Sep	(20 mos)……..	$53.00
Oct	(19 mos)……..	$50.00
Nov	(18 mos)……..	$47.00
Dec	(17 mos)……..	$44.00
Jan	(16 mos)……..	$41.00
Feb	(15 mos)……..	$38.00
Mar	(14 mos)……..	$35.00
Apr	(13 mos)……..	$32.00

Fees may be paid by check, money order, Visa or MasterCard.
Checks or Money Orders should be payable to Kansas Department for Aging and Disability Services or KDADS.
Charge authorization form must be completed and signed to pay by Visa or MasterCard.
All fees are non-refundable.

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
HEALTH OCCUPATIONS CREDENTIALING

Credit Card Charge for VISA or MASTERCARD

This charge is for: _____
(please print name)

As payment of license fees for:

- ¨ Speech-Language Pathology
- ¨ Audiology License
- ¨ Dietitian
- ¨ Adult Care Home Administrator
- ¨ Operator

Fee amount being paid $_____

VISA Card Number **(required)** _____

Expiration Date **(required)** _____

Or

MASTERCARD Number **(required)** _____

Expiration Date **(required)** _____

_____ _____
Name of Cardholder **(required)** Signature **(required)**